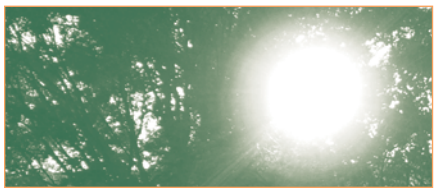
Transformation: Community Based

The division's commitment and focus are to serve more consumers at the community level where family and community supports and services can assist a person in recovery. Community services and supports have grown since the transformation legislation was passed by the General Assembly in 2001. More people are being served today in their communities than ever before. In state fiscal year 2004-2005, the public MH/DD/SAS system served 330,083 people with community services; that is 15,777 more individuals than in the year the transformation legislation was enacted.

In ongoing efforts to reach out to communities, Division Director Mike Moseley hosted three town hall meetings during the past year to promote a mutual

The LME-DHHS performance agreement requires LMEs to have 24-hours, seven-days-a-week crisis response services to ensure immediate response to persons in crisis without allowing authorization to delay needed services, including necessary commitments to a local or state psychiatric or detox facility, without regard to how the person entered the system.



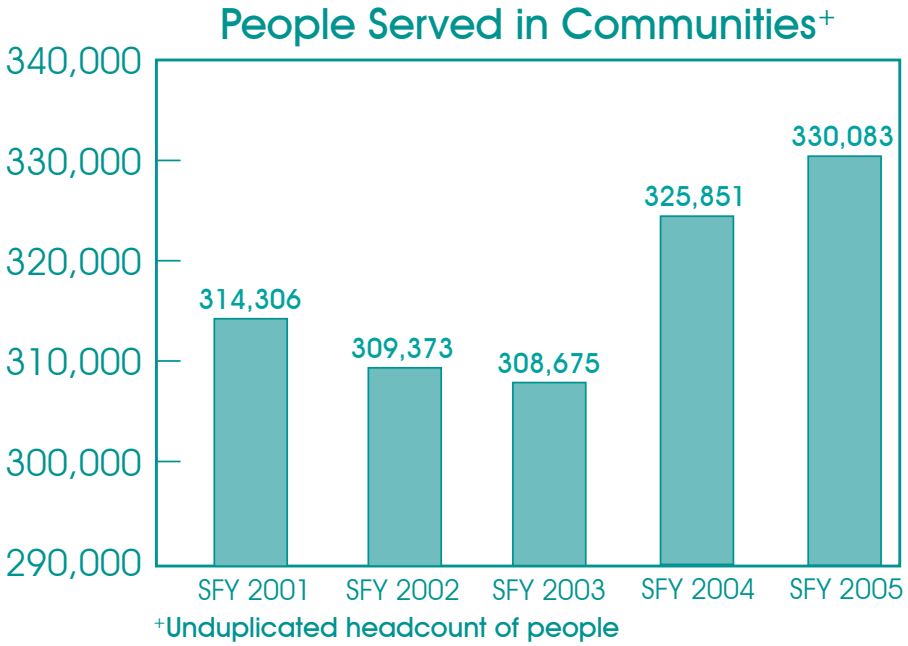
exchange of information and the opportunity to update communities about MH/DD/SAS. Meetings were held in Morganton, Greenville and Raleigh. More than 400 persons participated. In addition, Mr. Moseley completed site visits to all 32 existing LMEs at that time and all 15 state facilities, meeting with staff, consumers and community representatives.

To ensure community service providers have appropriate qualifications before providing services and receiving Medicaid funding, the division established a process in April 2005 that requires an endorsement by the local LME before a provider enrolls with the Division of Medical Assistance. All providers are required to follow the *Policy and Procedure for Endorsement of Providers of Medicaid Reimbursable MH/DD/SA Services*.

Transformation has required considerable change on the part of local management entities, communities, public and private providers and consumers and their families. For example, last year, the division published *Development of Community Based Crisis Stabilization Services* - guidelines for LMEs on the importance of establishing community based crisis services. The relationship of crisis services to access, screening, emergency services and referrals was clarified in a flow chart and facilitated

the development of operational procedures and data requirements. This document is also on the division's web site.

While community capacity is growing, the process is difficult and time consuming. The lack of community capacity in some areas of the state coupled with a significant increase in acute care admissions to the four state psychiatric hospitals has had an impact on the transformation efforts. While hospital admissions have increased, admissions tend toward short-term hospitalizations to resolve immediate crises. In the short-term, the division anticipates the higher number of hospital admissions will continue until communities develop and expand local crisis services and the development of detox capacity in the Alcohol and Drug Abuse Treatment Centers is completed. State facilities will continue to serve as the safety-net when community services and supports are not sufficient or appropriate for seriously ill consumers.



Total Persons Served by DMH/DD/SAS SFY 2005 (Duplicated Headcount)*		
	Local Management Entities	337,676
State Operated Facilities	Psychiatric Hospitals	18,435
	Alcohol and Drug Abuse Treatment Centers	3,732
	Developmental Centers	1,758
	Specialized Nursing Facilities	745
	Residential Programs for Children	170
	TOTAL	**362,516**

*A consumer may be counted more than once if he or she has more than one distinct admission/discharge event.

Transformation: Prevention Focus

Prevention is a proactive process focused on reducing risks or delaying or preventing the onset of problems. Prevention and early intervention are essential services for the general public and consumers with mental health disorders, developmental disabilities and substance abuse issues.

Last year, division staff oversaw funding and provided technical assistance for a wide variety of state and local prevention and early intervention initiatives, programs and activities. Conventions were organized; grants were awarded; public information materials were distributed; curricula were developed; and training was provided across the state. A sampling of the strategic initiatives included:

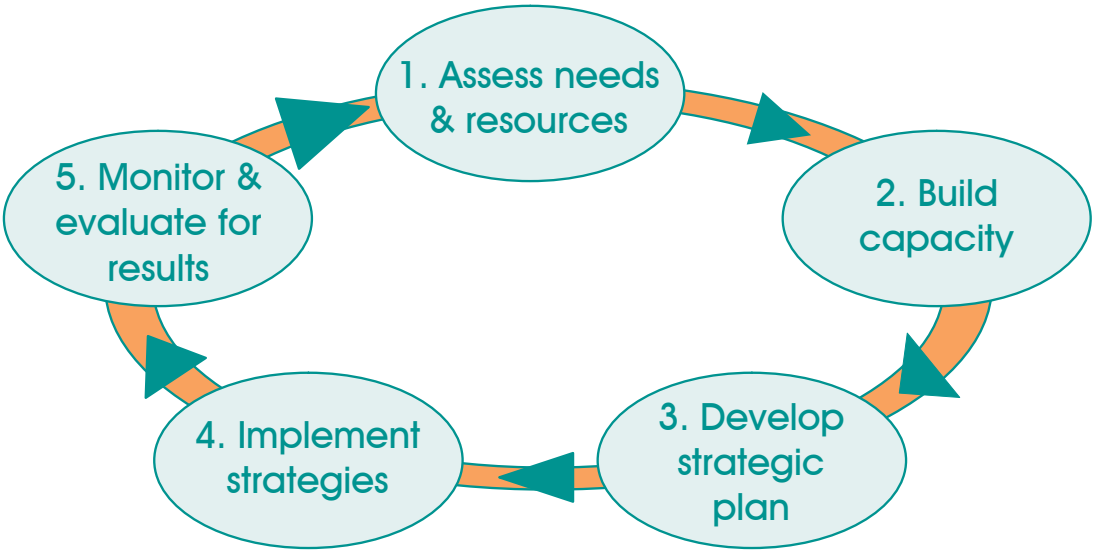
- First in Families of North Carolina – 10 projects created and governed by people with disabilities and their families to oversee and expand programs and create alliances of support within communities.
- Traumatic Brain Injury – An initiative that provides training, financial assistance and regional resource listings of best practices for individuals and their families.

- System of Care – Completed the fourth grant from the federal Center for Mental Health Services within the Substance Abuse and Mental Health Services Administration (SAMHSA) to implement comprehensive community based systems of care for children with or at risk of serious emotional disturbances and their families in over 20 counties in North Carolina.
- Safe and Drug Free Schools – An annual grant from the No Child Left Behind Act of 2001 designated by the governor of North Carolina to implement substance abuse and violence prevention programs in schools and communities.
- Synar Amendment – In agreement with the federal Department of Health and Human Services, an annual survey has been conducted since 1996 to determine the state's official rate of tobacco sales to minors through more than 800 attempted purchases by trained youth. Federal law requires states to reduce tobacco sales rates to minors to 20 percent or less. North Carolina's rates have fallen 50 percent in 10 years. A 2005 survey found the state's sales rate at 15 percent.

The division is developing a statewide prevention and early intervention plan with the input of partner agencies and other stakeholders. The plan adopts the Substance Abuse

and Mental Health Services Administration's five step model (*as shown below*) to guide the state and assist communities in establishing meaningful prevention and early intervention strategies to achieve priority outcomes; lower the prevalence of mental health, developmental disabilities and substance abuses; reduce the impact of stigma and lead to earlier intervention and improved treatment.

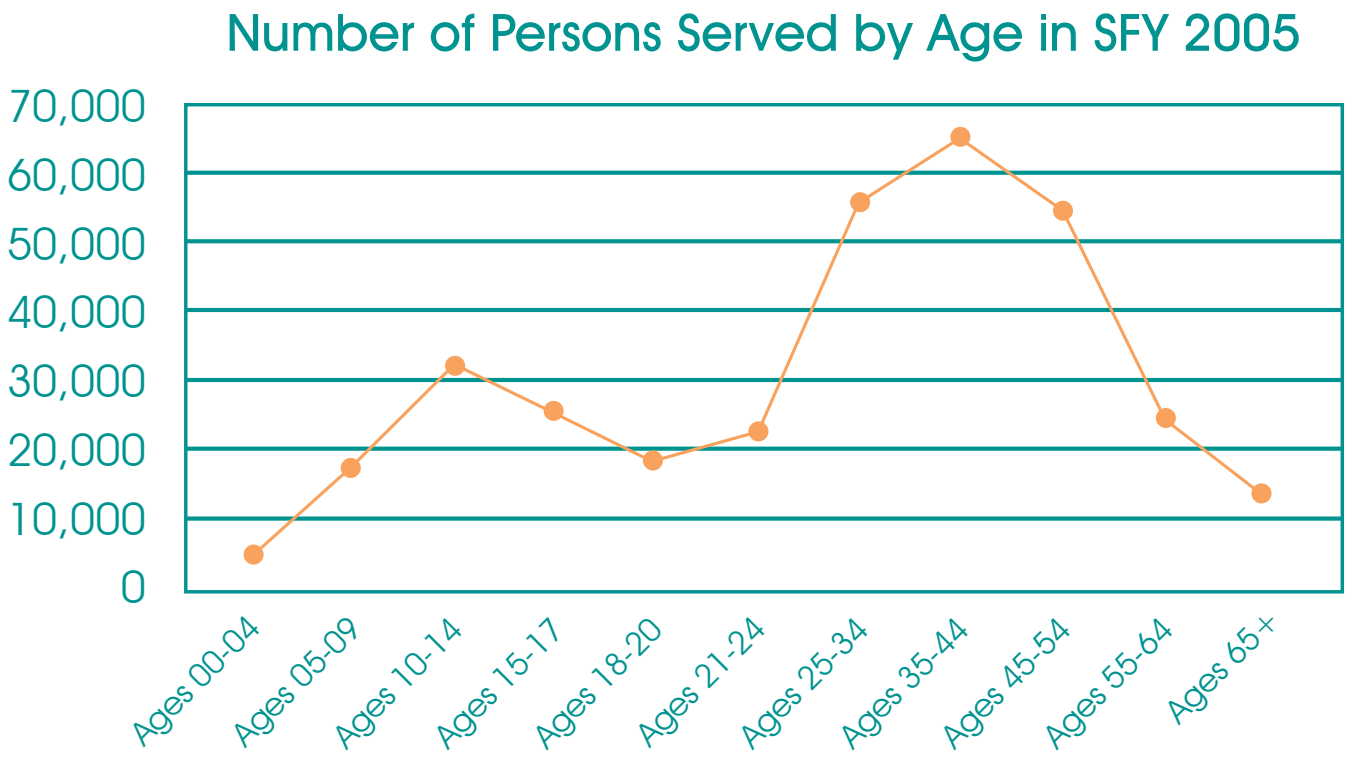
Prevention and Early Intervention Strategic Framework for State and Local Communities



Approximately one in every 26 North Carolinians uses the public MH/DD/SAS system each year.

In state fiscal year 2005, 18 percent of adults and 9 percent of children served through the public MH/DD/SAS system have multiple disabilities.

In state fiscal year 2005, the MH/DD/SAS system served 17 percent more Latinos, 4 percent more elderly and 6 percent more veterans than in state fiscal year 2003.


Number of Persons Served by Age in SFY 2005
70,000
60,000
50,000
40,000
30,000
20,000
10,000
0
Ages 00-04
Ages 05-09
Ages 10-14
Ages 15-17
Ages 18-20
Ages 21-24
Ages 25-34
Ages 35-44
Ages 45-54
Ages 55-64
Ages 65+

"Giving what I have to others is all that is required on this journey called recovery. It wasn't until my second psychotic break that medications were considered a viable solution. This was the first step towards my recovery that will hopefully last a lifetime. The utter despair I experienced as I just sat at home and did nothing or the embarrassment I felt as I ventured out into the public was all changed the day I met Sheri Carter, Director of Piedmont House. Ms. Carter said, "I think there is great potential for you in the system." Soon, I was attending the Piedmont House.

Transformation: Recovery Outcome Oriented

Recovery is widely used in reference to substance abuse problems. The word recovery is less familiar in the mental health or developmental disabilities services and supports system. The concept of recovery from mental illness is now in the spotlight.

The term recovery is now widely accepted as a key national goal of mental health and substance abuse services. The President's New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America* report says, for some people recovery is the ability to live a fulfilling and productive life despite a disability; for others it implies the reduction or complete remission

of symptoms. Recovery refers to all people served.

Recovery-based care in mental health settings continues to be defined nationwide. One example of division activity is its promotion of peer support groups and Wellness Recovery Action Planning (WRAP). The division contracted with the North Carolina Mental Health Consumers Organization to conduct WRAP training. Last year, the nonprofit organization provided training across the state to 448 adult mental health consumers, refresher WRAP courses to an additional 116 consumers and training to nine consumers who are now qualified as WRAP facilitators. The WRAP national curriculum focuses on development of personal skills, such as:

- How do you advocate for yourself?
- What do you do to keep yourself well?
- Do you have a crisis plan and an advanced directive?

One of the most educational meetings that I attend regularly and have been an active member in is the Piedmont Behavioral Healthcare Consumer and Family Advisory Committee (CFAC). In addition, the North Carolina Mental Health Consumers Organization (NCMHCO) recruited me to be trained as a Wellness Recovery Action Plan (WRAP) facilitator for their organization. I have traveled the state introducing people to WRAP, a plan that helps people get well and stay well for long periods of time. Eventually I was hired as a part-time Peer Support Specialist at Piedmont House, where I interact with

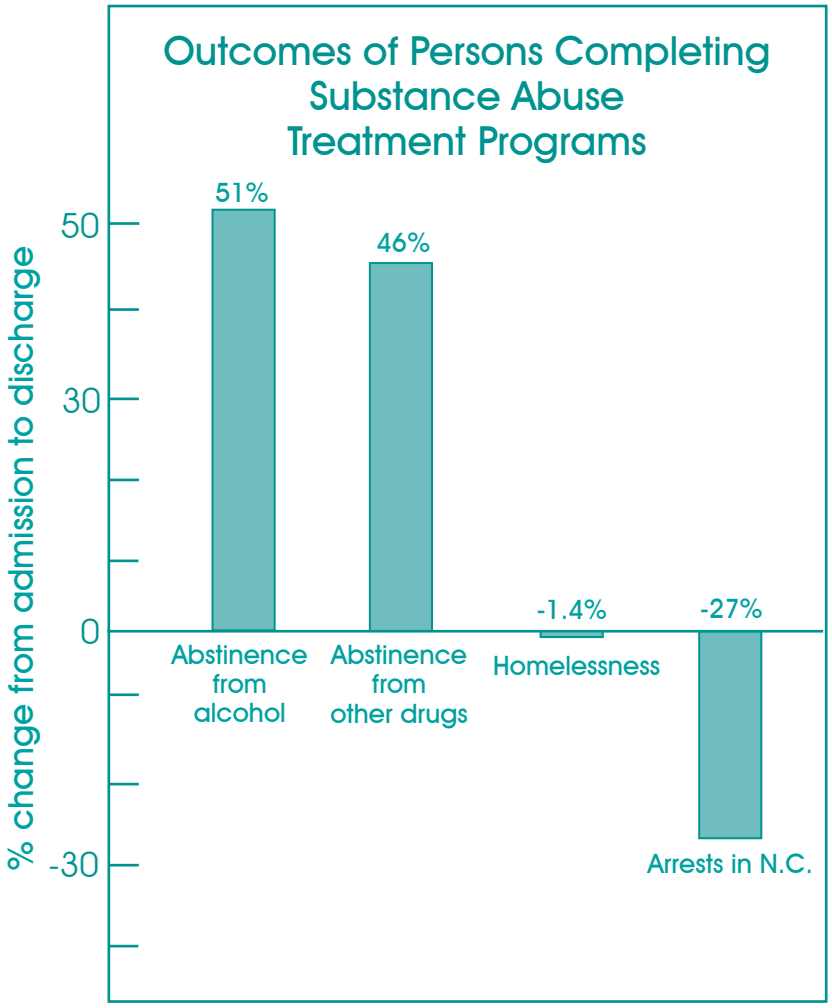
others like myself. Currently, I am seeking full-time paid employment and would like to move into a position assisting with the ACT team (Assertive Community Treatment Team). This would mean I would no longer need SSDI (Social Security Disability Insurance) and that is a great step in the right direction on the road to recovery. I can assist others in similar situations and hopefully offer them something only someone like me can, whether it is compassion or humility."

- By Bart Kean

Recovery is also supported by the power of consumer choice of goals and of providers. The new MH/DD/SAS system guarantees that consumers direct the process of person-centered planning by defining their own real life goals and outcomes. The individual or family shares authority and responsibility with service providers.

Last year, the division conducted an expansion of the revised NC Treatment Outcomes and Program Performance System (NC-TOPPS). This is a web-based process of collecting information about consumers' quality of life and service needs to track the outcomes of services. Previously, NC-TOPPS interviewed 20 percent of consumers of selected substance abuse services. Now, 100 percent of children and adults receiving mental health or substance abuse services participate in a periodic interview that measures life outcomes, such as having a job or adequate housing. Last year all LMEs

and providers were trained in this new web-based process of collecting data for use by July 1, 2005. Outcomes for consumers with developmental disabilities are measured by the National Core Indicators and the Consumer Outcomes Inventory (DD-COI) and are based on interviews of a sample of consumers. This process has been in use for a number of years.



"We insist on a system that rewards and builds on what works and abandons those efforts that do not."

- Mike Lancaster, MD, clinical director, DMH/DD/SAS

Transformation: Reflect Best Treatment/Support Practices

The division directs both staff time and financial resources in an effort to bring evidence based and best practices to North Carolina as well as exploring emerging and promising practices. The division is committed to practices that meet the highest standards and have reliable results.

Working intensely this past year with the Division of Medical Assistance, the division successfully crafted new and revised service definitions to be supported by Medicaid. They include evidence based practices proven by at least three independent research studies each. Other services are promising or emerging best practices. The service definitions must be approved by the federal Center for Medicare and Medicaid Services. These service definitions can be viewed at: ***www.dhhs.state.nc.us/mhddsas/***.

To inform providers and staff from state agencies and LMEs, as well as consumers and family members, division staff conducted three full-day orientations to the proposed service definitions. From January to March, over 1,800 people attended the training sessions in either Charlotte or Raleigh.

The division also sponsored two videoconferences for consumers and family members on service definitions. They were broadcast to 21 sites in 20 cities throughout the state. The training handouts and audio visual presentation are available on the web: ***www.dhhs.state.nc.us/mhddsas/consumeradvocacy/index.htm***.

In other educational efforts, the division has ongoing contracts with the Behavioral Healthcare Resource Program and the Developmental Disabilities Training Institute of the University of North Carolina at Chapel Hill. These contractors train and mentor private trainers to educate local LME and provider staff in depth on person-centered planning, community support and other service definitions.

The division also expanded its support of two long-standing, well-attended training events – the Community Support and Targeted Case Management Conference and the Consumer Rights and Empowerment Conference. New this year was a Best Practice Conference.

Transformation: Cost Effective

Being good stewards of state and federal money is the key to public credibility and legislative support. The division worked with the state Commission for Mental Health, Developmental Disabilities and Substance Abuse Services; the DHHS Divisions of Facility Services, Medical Assistance and Vocational Rehabilitation Services; and the Department of Public Instruction to establish rules, develop licensure manuals and develop programs.

To establish reasonable local administrative costs, the division developed a cost model of the primary functions for a local management entity based on serving a minimum catchment area of 200,000 residents. Last year allocations were made to LMEs according to their population base. LME capabilities continue to evolve in these areas to balance quantity, quality and overall cost.

The division received funding through the North Carolina Mental Health Trust Fund to support transformation. In the past four years this fund provided over $42 million to communities to help build community capacity. This community capacity building is in preparation for consumers as they leave facilities or residential settings to receive services and supports in their community. For example,

awards totaling $1.6 million were made to nine LMEs last year for the development of intensive in-home services for children and families.

The division examined prior year expenditures and the effectiveness of programs. One result was a revision of division policies to allow LMEs to use up to 10 percent of specific allocations for non-unit cost reimbursement (UCR) purposes to strengthen community focus. Consequently during the last year:

- The division approved 18 LMEs to use a portion of Comprehensive Treatment Services Program (CTSP) allocations. This program improves outcomes for children and families through crisis care, prevention and early identification activities, training for families and community members, workforce training and other activities.
- The division approved two LMEs to use a portion of mental retardation/mental illness (MR/MI) funds to develop additional community services. The funds are used for adults who have developmental disabilities and who have received long term care in a state psychiatric hospital and/or are eligible under the 1999 Supreme Court's Olmstead decision. The Olmstead decision required states to develop more opportunities for individuals with disabilities through community

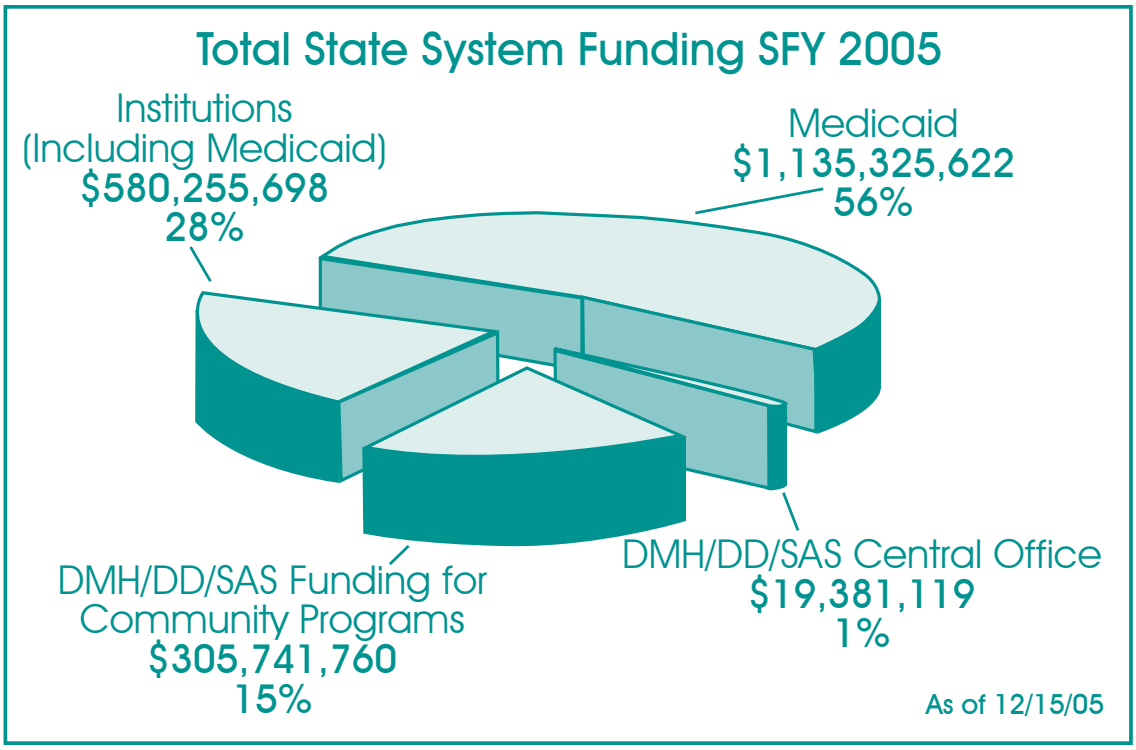
based services and to establish the most appropriate community setting for individuals with disabilities rather than in institutions.

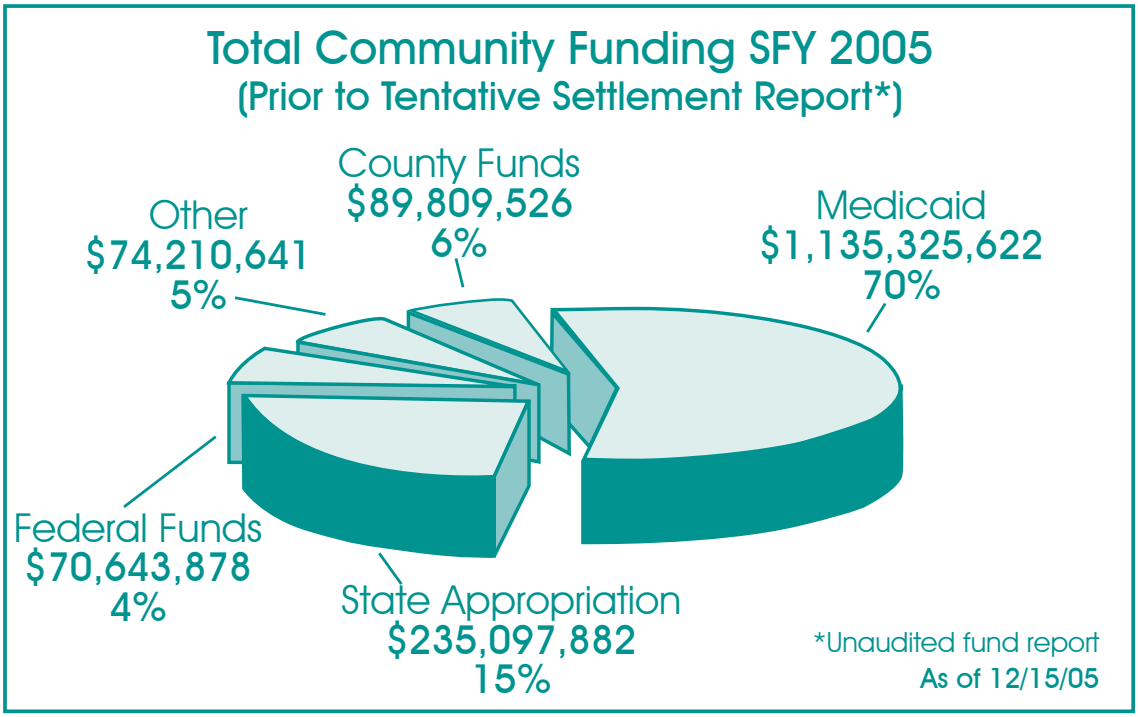
LME functions

- *General administration and governance*
- *Business management and accounting*
- *Information management*
- *Provider relations*
- *Access/screening/triage/referral*
- *Service management (utilization, authorization and service coordination)*
- *Consumer services*
- *Quality improvement*

In January 2005, at the behest of Governor Mike Easley, DHHS Secretary Carmen Hooker Odom suspended all new licenses for children's residential treatment facilities until a statewide review was conducted of every home. The division and the Division of Facility Services inspected all 1,054 facilities across the state to determine compliance with the North Carolina Administrative Rules. As a result, 10 percent surrendered their licenses and 29 percent were vacant. Of the remaining 949 facilities, 420 facilities were found to be in compliance. Administrative sanctions and/or standard deficiencies are being addressed for the remainder. It is anticipated licensure suspension will not be lifted until the new child residential rules go into effect to better safeguard the health and safety of children served in these facilities. In

addition, the division implemented a statewide system for clarifying how providers and LMEs report and monitor incidents of consumer injury and death in all facilities.





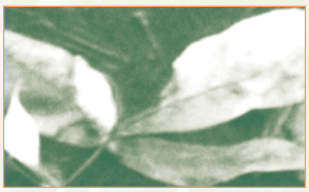
Transformation: Plans for the Future

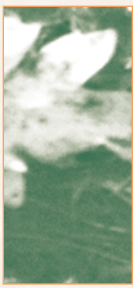
For everything accomplished there is still much left to do for the transformation of MH/DD/SAS in North Carolina. In the future, the division plans to:

- Support the further development of community capacity and long range planning with particular emphasis on age-appropriate crisis service development.
- Ensure that the workforce is properly trained and culturally competent.
- Implement the proposed service definitions because they are fundamental to how providers get paid for services.

"It is important that we support community based services and make consumers the focus of our attention, efforts and funding."

- Leza Wainwright, deputy director, DMH/DD/SAS





- Continue identifying those emerging and promising prac-tices as approaches evolve and change.

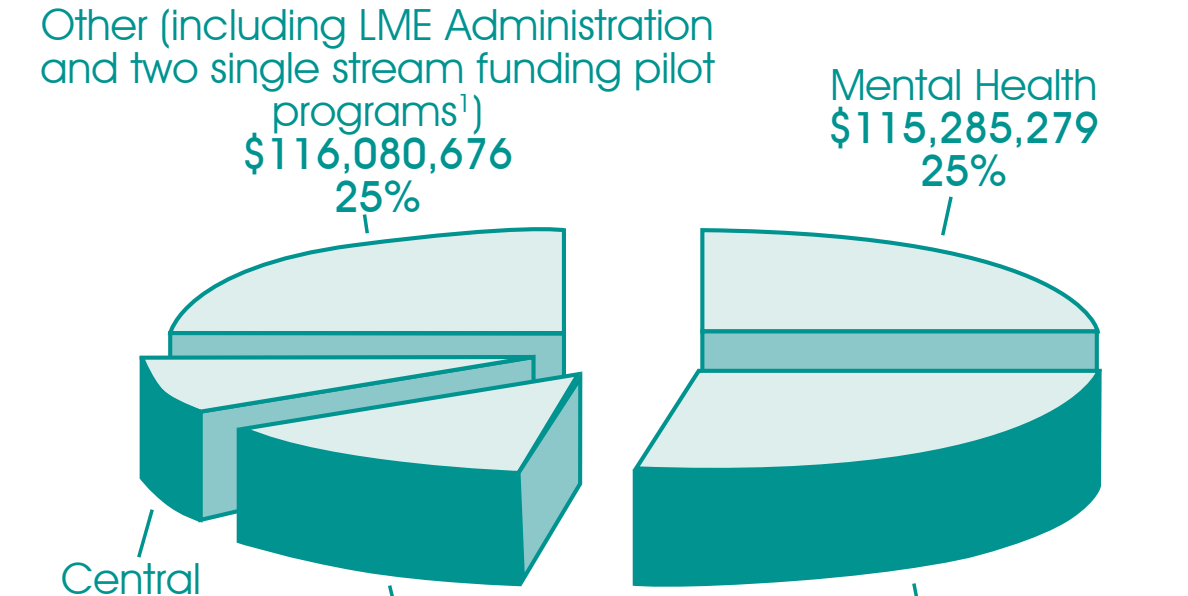
- Develop a long-term finance strategy to ensure adequate funding for all the division's services.

And finally, there is great anticipation for the construction, completion and operation of the new hospital facility in Butner that will serve 33 counties in central North Carolina.

The era of transformation for the MH/DD/SAS system is here and now. Our attitude, our services, our way of making sure that the consumers, families and communities who depend on us are better served, will most certainly set a new higher standard for us and others to follow.

Please share your ideas, your input and your concerns. After all, this is your mental health, developmental disabilities and substance abuse services system.

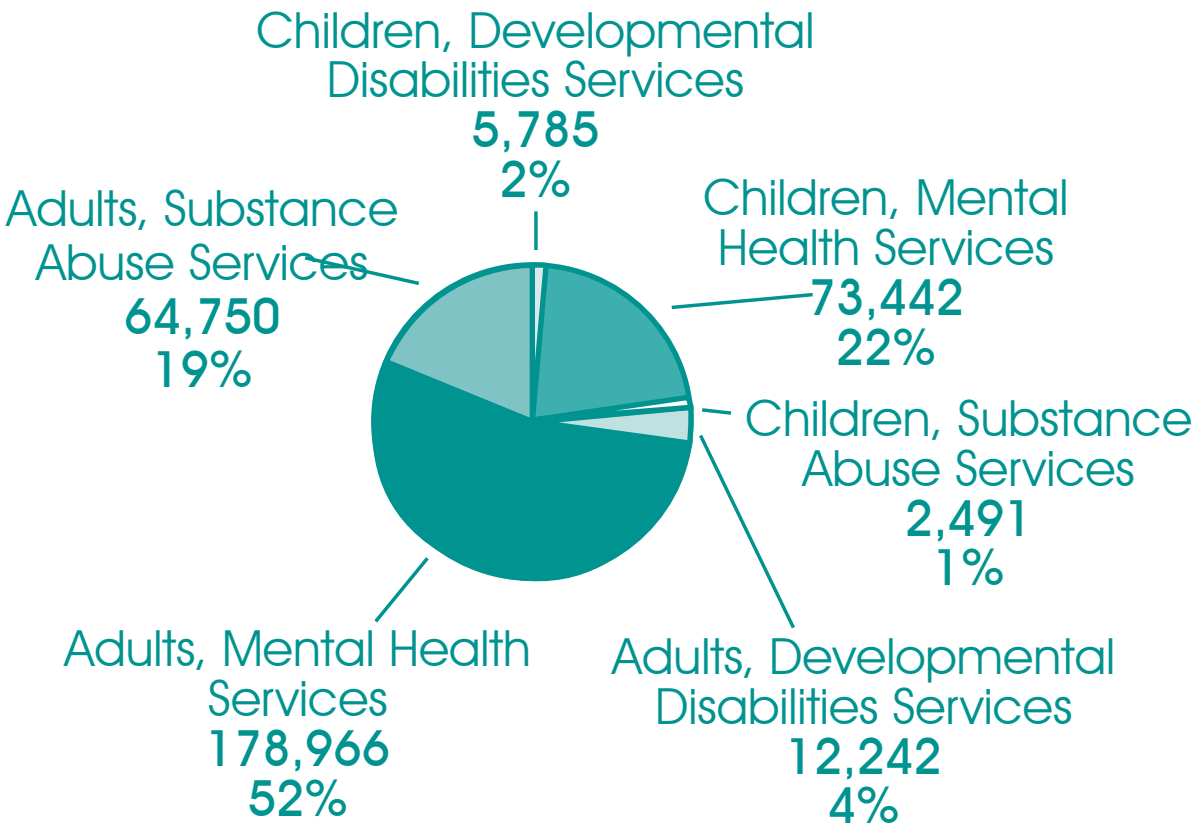
Community Program Disability Specific Funding SFY 2005 (Not Including Medicaid)



[1] Pilot programs – Piedmont and Smoky Mountain

Persons Served by Primary/Co-Occurring Disability SFY 2005

(Duplicated Headcount)*



*A consumer may be counted more than once if he or she has more than one distinct admission/discharge event.

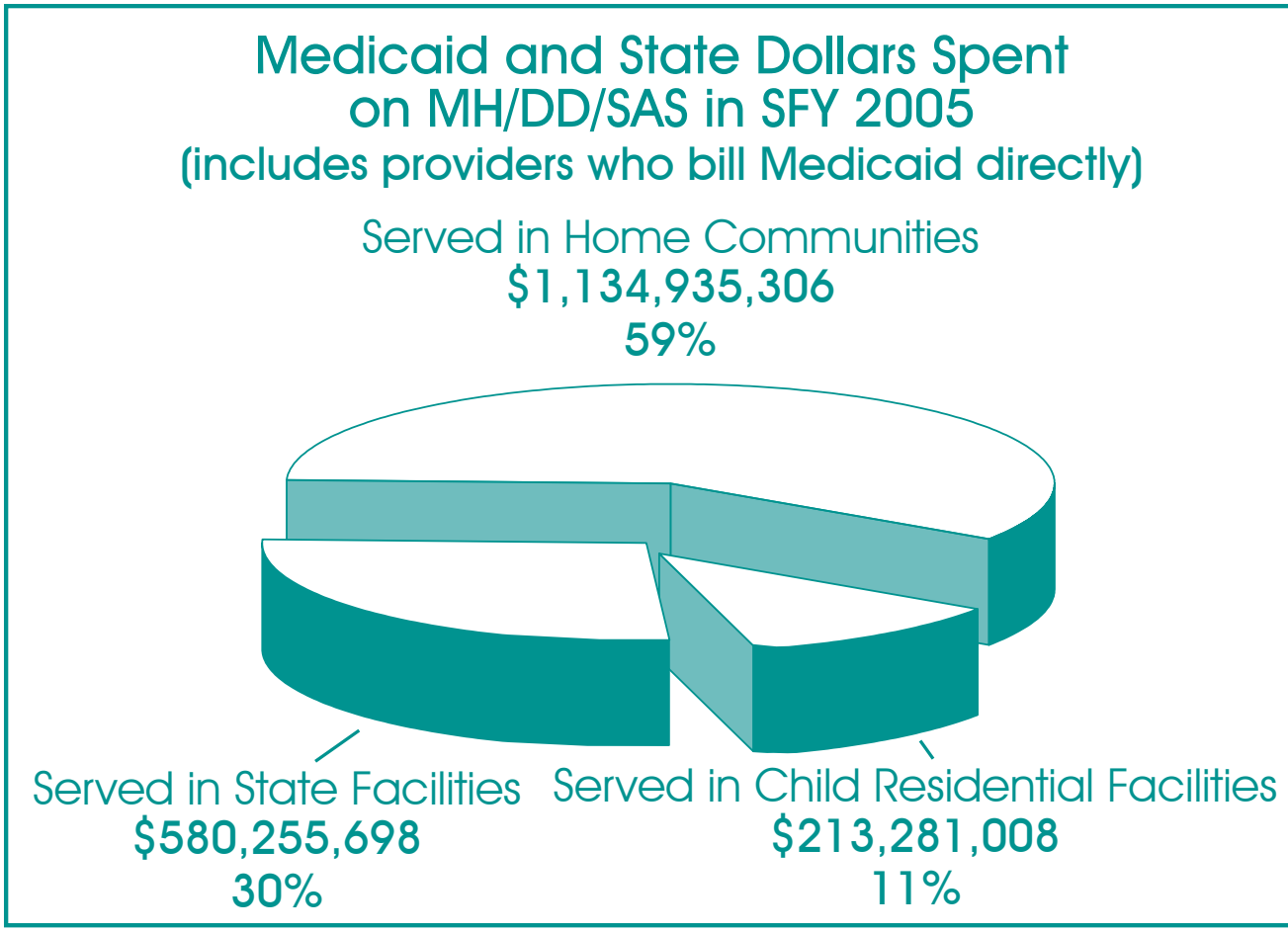
Consumer Demographics of Persons Served by LMEs SFY 2005 (Duplicated Headcount)*

RACE	Female Child	Female Adult	Male Child	Male Adult	Total
American Indian/ Alaskan Native	450	2,173	788	1,908	5,319
Asian	128	407	192	406	1,133
African American	11,814	40,126	21,450	45,187	118,577
Multiracial	4	0	3	3	10
Other	2,309	4,416	3,552	4,586	14,863
Pacific Islander	0	3	3	2	8
White	15,983	83,476	25,042	73,265	197,766
Total	**30,688**	**130,601**	**51,030**	**125,357**	**337,676**
(%)	**(9%)**	**(39%)**	**(15%)**	**(37%)**	**100%**
					As of 11/30/05

*A consumer may be counted more than once if he or she has more than one distinct admission/discharge event.

Medicaid and State Dollars Spent on MH/DD/SAS in SFY 2005

(includes providers who bill Medicaid directly)



*A consumer may be counted more than once if he or she has more than one distinct admission/discharge event.

Central Regional Psychiatric Hospital

nc department of health and human services

State of North Carolina • Michael F. Easley, Governor
Department of Health and Human Services
Carmen Hooker Odom, Secretary

www.dhhs.nc.state.us

03/06

North Carolina Division of Mental Health,
Developmental Disabilities and Substance Abuse Services
3001 Mail Service Center
Raleigh, NC 27699-3001

Location: 325 Salisbury Street, Albermarle Building, Raleigh, NC 27603 / (919) 715-3197 / www.dhhs.state.nc.us/mhddsas/